OFFICE OF THE INSPECTOR GENERAL FOR MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

Primary Inspection
Southwestern Virginia Mental Health Institute

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Inspector General

Report #116-05

SOUTHWESTERN VIRGINIA MENTAL HEALTH INSTITUTE
MARION, VIRGINIA
March 29-30, 2005
OIG Report #116-05

INTRODUCTION: The Office of the Inspector General (OIG) conducted a primary inspection at Southwestern Virginia Mental Health Institute (SWVMHI) in Marion, Virginia during March 29-30, 2005. The inspection focused on a review of the facility through the application of 19 quality statements. These statements are grouped into 6 domains that include facility management, access to services, service provision, discharge, quality of the environment, and quality and accountability. The quality statements were formulated through interviews completed by the OIG with a number of stakeholder groups. These groups included the mental health facility directors, consumers, Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) Central Office administrative staff, DMHMRSAS Office of Mental Health Services staff and directors of mental health services for community services boards (CSB). The quality statements and the information obtained by the OIG through observations, interviews and a review of documents are described in this report. The report is divided into sections that focus on each of the domains previously noted.

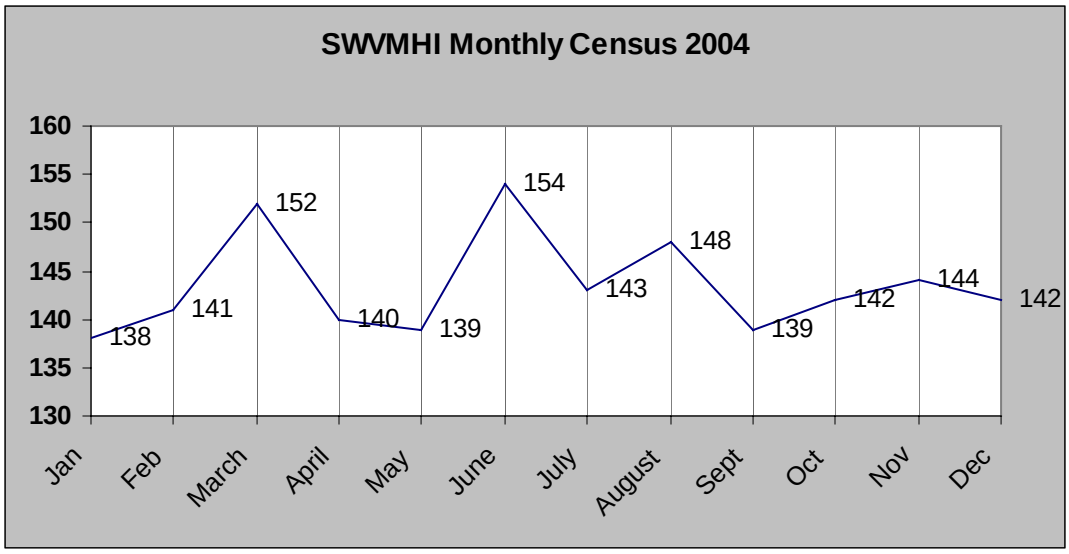
SOURCES OF INFORMATION: Interviews were conducted with 31 members of the staff including administrative, clinical and direct care staff. Interviews were also completed with 18 consumers. Documentation reviewed included, but was not limited to 4 clinical records, selected policies and procedures, staff training curricula, facility quality management plan, and risk management reviews. A tour of the facility was conducted. Graphs and charts in this report were created from data provided by the facility.

BACKGROUND: SWVMHI is the only facility operated by DMHMRSAS that provides services for adolescents, adults and the geriatric population. The facility is the primary hospital for 9 CSBs, including Planning District 1, Cumberland Mountain, Dickenson, Highlands, Mt. Rogers, New River Valley (adults and adolescents only), Blue Ridge Community Services (adolescents only) and Dansville- Pittsylvania (adolescents only).

The budget for SWVMHI in FY 2004 was $28,126,239, with reported expenses for the same period of $28,126,244. The budget for FY 2005 is $28,931,972. This is $805,728 greater than the actual expenses for FY2004. Administrative staff reported that the facility-wide cost per bed day is $531.06. During the first quarter of 2005, the average cost per bed day for each of the 5 service areas was:

Adolescent	$1,459
ICF	$549
Community Prep	$504
Acute Admissions	$674
Medical (Infirmary)	$2,487

The facility's operating capacity was reported to be 172 beds. At the time of the inspection, the facility had a census of 168 consumers. The census on the first day of each month during calendar year 2004 was as follows:



According to information provided by the facility, the average daily census has decreased from 181 in CY2000 to 146 in CY2004.

The average daily census by ward per calendar year for the period 2000 through 2004 was as follows:

	CY00	CY01	CY02	CY03	CY04
Adolescent Unit	**11**	**11**	**7**	**7**	**5**
Admissions	**60**	**58**	**55**	**52**	**56**
Extended Rehab Services	**81**	**49**	**49**	**49**	**49**
Geriatrics	**27**	**33**	**37**	**37**	**35**
Infirmary	**2**	**2**	**1**	**1**	**1**
TOTAL	**181**	**153**	**149**	**146**	**146**

MENTAL HEALTH FACILITY QUALITY STATEMENTS

Facility Management

1. The facility has a mission statement and identified organizational values that are understood by staff.

The mission of Southwestern Virginia Mental Health Institute is as follows:

> *Health…Healing…Hope. As an important component of an integrated mental health system, the Institute serves all the citizens of Southwestern Virginia through continuing excellence in the provision of care.*

This mission statement does not clearly define the work of the facility. This was confirmed by the fact that the majority of staff who were interviewed (18 of 25) were not able to describe what the facility is trying to achieve with consumers. They were not clear on the mission of the facility despite the fact that the official mission statement is posted throughout the facility and is printed on the back of the employees' identification tags. A number of staff stated that the hospital should re-evaluate its mission and become more focused on services that address the individualized needs of the consumers. Several others told the OIG that a significant number of the consumers at the facility have substance abuse problems yet there is little focus on substance abuse treatment. Other staff shared that despite the fact that a number of residents are mentally retarded the facility is not well equipped to serve the individuals.

The established organizational values were reviewed and updated last fall. The values as outlined in the facility's 2005 Plan for Patient Care Services include the following:

It is our belief that excellence is achieved by:

- *Focusing on our primary customers – our patients*
- *Creating and maintaining a healing learning environment*
- *Communication, problem solving and Trust*
- *A process of continuous improvement*

Only 3 of the 25 staff members interviewed were able to identify three values that govern the work of the facility. The majority of those interviewed provided the "golden rule" as the primary value of the facility.

2. The facility has a strategic plan.

Administrative staff reported that the strategic plan for the facility, which was updated in Fall 2004, has four goals or success factors. These include:

1. Ensure financial viability by utilizing the best of managed care
2. Continuously improve quality of care and patient and staff satisfaction

3. Continuously assess and respond to wants and needs of external customers
4. Advocate for MHMRSAS needs in Southwestern Virginia

The Executive Management Committee updates the facility's goals and objectives annually. The OIG was told that during the most recent review, the committee considered the priorities and initiatives of the Southwest Virginia Behavioral Health Board in the formulation of the plan.

3. The mission and strategic plan have been reviewed and are linked to the recently adopted DMHMRSAS Vision Statement.

SWVMHI has not reviewed the mission and values of the facility in light of the recently adopted DMHMRSAS Vision Statement. Administrative staff reported that as the facility is reviews its vision and mission statements in preparation for the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) review, these statements will be examined for common themes with the recently adopted DMHMRSAS documents.

4. There are systems in place to monitor the effectiveness and efficiency of the facility.

SWVMHI has a number of systems in place to monitor the effectiveness of the services provided. The facility's strategic plan calls for the measurement of both clinical outcomes and patient satisfaction. It is primarily the responsibility of the Quality Management Committee to determine how these goals will be monitored and measured. Monitoring occurs on the organizational level through various committees, performance improvement initiatives and quality assurance activities. Measures are established by the various disciplines to monitor effectiveness. For example, the most recent performance improvement plan for nursing services (FY2005) called for the monitoring of performance in the following areas:

- Medication variances
- The use of at least 2 patient identifiers whenever administering medications or providing any other treatment or procedures
- Read-back of complete verbal or telephone orders and critical test results
- Compliance with DMHMRSAS staffing standards
- Assessment of each patient's risk of falling

Administrative staff reported that efficiency is measured within the context of the budget. This involves an ongoing review of measures such as the use of overtime, the number of vacancies, staff turnover and cost of service provision.

5. There are systems in place to assure that there is a sufficient number of qualified staff.

Administrative staff reported that maintaining a sufficient number of qualified nursing staff has not been a major issue for SWVMHI. Occasionally, the facility does have a

challenge filling other professional clinical positions such as psychologists, and psychiatrists.

The facility assures that staff is qualified to perform assigned duties beginning with the application and screening process. The facility establishes hiring criteria for each position. There is a careful screening of all applicants to assure that their knowledge, skills and abilities match the hiring criteria. The six-week orientation process for direct care staff includes classroom instruction and on-unit training. Individuals in direct care nursing positions are required to become certified nursing assistants (CNA) within 120 days of employment. SWVMHI supports staff in meeting this requirement by providing time, transportation and opportunities to complete the necessary courses.

Annual training regarding key policies and procedures is required. Competencies are established for all direct care and clinical positions. Staff is expected to pass written tests or demonstrate competence in key tasks. Peer reviews and required continuing education for licensed practitioners provide ongoing avenues to enhance staff skills.

Data provided by the facility revealed that SWVMHI has 531 approved full-time employee positions, 518.5 of which were filled at the time of the inspection. Of these full-time positions, the following were assigned to direct care and nursing:

173 Direct Service Associate II
18 Direct Services Associate III
22 licensed practical nurses
20 RN-I
45 RN-II
23 nurse managers

SWVMHI staffing also included the following numbers of clinical staff:

- 8FT physicians including 6 psychiatrists and 2 internists. The Medical Director position is vacant.
- 9 FT psychologists including the director. Seven have doctoral degrees, and 2 have masters degrees.
- 17 FT social workers including the director. Eight have Master's degrees; 5 are licensed clinical social workers; 4 have bachelor's degrees.
- 13 FT activity therapists including 2 occupational therapists, 1 certified occupational therapy assistant and 10 recreational therapists.

Staffing patterns for registered nurses (RN), licensed practical nurses (LPN) and certified nursing assistants (CNA) were as follows:

MARCH 29, 2005 (DAY SHIFT)

Adolescent Unit
2 RNs, 1 CNA — 2 consumers

Unit J (Long Term)
2 RNs, 1 LPN, 4 CNAs — 14 consumers

Unit I
3 RNs, 1 LPN, 8 CNAs — 17 consumers

MARCH 29, 2005 (EVENING SHIFT)

Unit C/D
2 RNs, 2 LPNs, 5 CNAs — 24 consumers

There was an additional CNA for part of the shift because 2 of the consumers were on constant observation.

MARCH 30, 2005 (DAY SHIFT)

Unit A/B
4 RNs, 2 LPNs, 10 CNAs — 27 consumers.

Staffing was higher on this unit because there were 2 consumers on 1:1 status and 8 consumers on constant observation status.

Unit K (Infirmary)
1 RN, 2 CNAs — 4 consumers

MARCH 30, 2005 (EVENING SHIFT)

Unit E/F
4 RNS, 1 LPN, 8 CNAs — 36 consumers

There were 2 consumers on constant observation.

Unit J (Long Term)
3 RNs, 1 LPN, 2 CNAs — 14 consumers

6. There are mechanisms for direct care staff and clinical staff to participate in decision-making and planning activities.

Administrative nursing staff reported that the facility has an effective system of communication between nursing supervisory staff and the direct care employees. In addition to regularly scheduled unit and departmental meetings, supervisory staff

conducts shift rounds to address any issues that arise and to provide staff with information.

Fifteen of the 18 staff interviewed regarding this quality statement reported having opportunities to participate in decision-making and planning activities. The direct care staff stated that they could discuss concerns with their supervisors but did not outline other ways of being involved such as on committees, performance improvement teams or even treatment planning activities. Clinical staff and RNs reported more ways of being involved in decision-making activities than the direct care staff interviewed.

It was reported that the facility director intends to go to all the units across the various shifts to meet informally with staff and to hear their concerns.

7. Facility leadership has a plan for creating an environment of care that values employees and assures that treatment of consumers is consistent with organizational values.

The administrative staff interviewed discussed several strategies underway for accomplishing this. Valuing employees and consumers through increased satisfaction and improved quality of services is one of the four critical factors identified in the facility's strategic plan. This measure is addressed in a number of initiatives, such as the proposed unit visits by the facility director.

Administrative staff stressed that the employee's immediate supervisor serves as the most important link in expressing appreciation for the work of staff. Supervisors are trained and encouraged to actively praise persons they supervise when it is warranted. The facility has a reward program for attendance. Administrative staff reported that the facility is currently reviewing ways to enhance its staff recognition programs. The facility hosts Nurses Appreciation events during National Nurses Week and unit Christmas parties to highlight and recognize the employees.

Fourteen of the 21 direct care staff members interviewed, regarding this quality statement, reported feeling valued by their supervisor and nursing leadership. Only 4 of the 21 reported feeling valued by facility leadership, in general. Staff shared that there are a number of special activities designed to validate the contributions of nurses within the setting but felt more attention could be paid to other classifications.

Access

1. There are systems in place to assure that those admitted to the facility are appropriate.

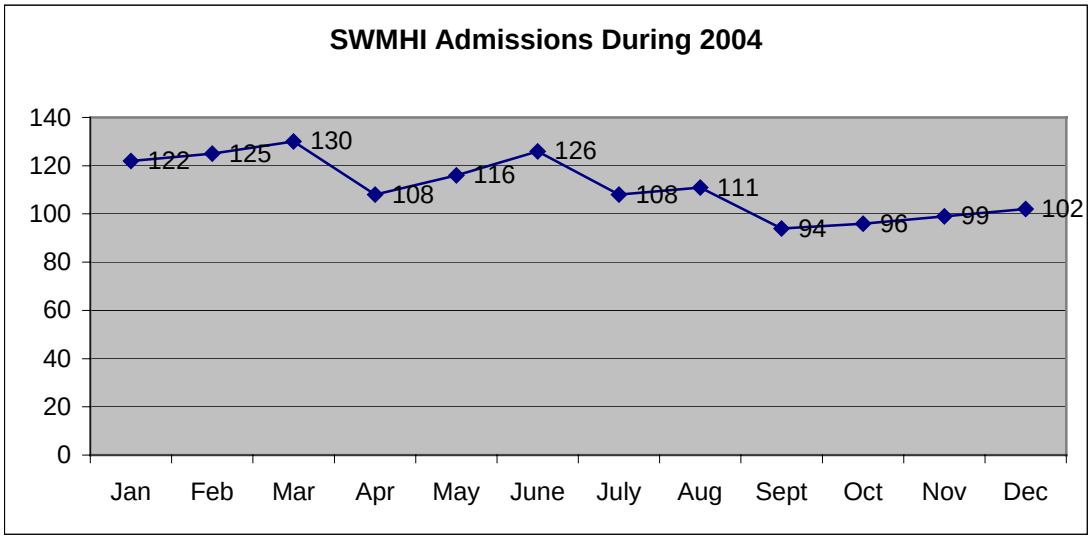
Staff interviewed reported that the majority of admissions to the facility have temporary detention orders (TDO). They reported that those admitted under TDOs have a high likelihood of medical concerns in conjunction with the presenting acute psychiatric conditions. It was also noted that the majority of admissions occur after 5:00 pm and on

the weekends and holidays, when the majority of clinical staff are not available. Staff who are involved in the admissions process have been trained to assess the appropriateness of the admission and to work with the prescreener in assuring that hospitalization is the least restrictive option. The admissions staff must also assure that the presenting factors with the forensic population include an acceptable level of risk for facility placement.

Interviews, a review of the facility admission policy and a review of clinical records demonstrated that the facility has a system for assuring appropriate admissions. As with all DMHMRSAS operated facilities, the prospective consumer must be assessed by a prescreener from the appropriate CSB prior to being admitted. The prescreener determines whether the consumer meets the criteria for admission to an acute care setting, which is determined by the presence of imminent risk to harm self or others or substantial inability to care for self due to a mental illness.

Facility data revealed that there were 1,462 requests for admission during CY2004 with 1,327 admissions. Of the admissions, 790 were male and 537 were female.

Data for CY2004 provided by the facility to the OIG reported monthly admissions as follows:



The three most frequent reasons provided by the facility for denying an admission included:

- The person did not meet the criteria for inpatient care
- The person had acute medical needs that could not be addressed within the setting
- The person was a high risk forensic referral who was not appropriate for the setting

2. The facility works collaboratively with CSB's to assure access to appropriate services when admissions to the facility are inappropriate or not possible due to census.

Staff indicated that appropriate admissions to the facility are never denied because of census considerations. Admissions staff and prescreeners discuss the least restrictive options for care at the time of the admission request. The facility works cooperatively with the CSB prescreener to assure that the consumer receives the appropriate level of treatment and placement when the referral does not meet the criteria for admission or needs a more secure setting. Admission staff reported valuing their relationship with the CSB and working hard to assist the prescreener in having a positive experience when seeking placement for a consumer. Facility personnel meet regularly with emergency services personnel in the CSBs to review admissions and to address any concerns or issues regarding the admissions process.

Census management is an important concern of the facility. It was reported that there are approximately 140 private inpatient beds in six facilities in this region. Typically, these beds are used for persons with lower acuity and complexity than those referred to SWVMHI for treatment. Each admission to SWVMHI is carefully reviewed, including the reasons that an acute admission was not accepted in a private facility so that this information can be effectively communicated in regional planning meetings regarding diversion services.

Service Provision

1. There are systems in place to assure that the consumer receives those services that are linked to his/her treatment plan and identified barriers to discharge.

Service provision at SWVMHI includes the integration of psychotropic medications, psychosocial rehabilitation programming, behavioral treatment, and the fostering of a safe and supportive environment of care. It was relayed that all treatment is designed to promote the type of symptom control and functional living skills necessary for the consumer to successfully reside in the community. Administrative staff reported that the facility strives to enhance each consumer's hopes, motivation and abilities through individualized active treatment programming.

Each person admitted to the facility undergoes a series of assessments by a number of disciplines. A nursing screening of both medical and psychiatric risk factors occurs within the first half-hour of the admission process. A complete physical examination and psychiatric evaluation are completed within the first 24-hours. The majority of assessments are to be conducted prior to the formal treatment planning session, which occurs within seven days of admission. These assessments become the basis for developing the individualized treatment plan. Clinical staff indicated that treatment objectives are prioritized with a focus on those objectives that are related to "barriers" to the person re-entering the community. Consumers are active participants in identifying their treatment goals and in making choices regarding treatment programming.

Consumers are asked to comment on the effectiveness of the groups in addressing their goals and objectives. This feedback is used to develop programming options.

SWVMHI has contracted with the Boston Center for Psychiatric Rehabilitation since 1999 to provide consultation and training regarding the Center's active treatment philosophy and principles. This model endorses assisting persons with serious psychiatric disabilities to function successfully in the environment of their choice and by their definition of successful living. This philosophy calls for the establishment of a partnership between the provider and the consumer in crafting a plan for increased functioning throughout the recovery process. SWVMHI has implemented programming that is designed to meet the individual needs of the consumer. This requires the completion of a readiness assessment and identifying with the consumer how to best proceed in moving towards the established goals. Groups are offered in the various stages of recovery from readiness development through engagement to achieving.

Rehabilitation services at SWVMHI have three components: Central Rehabilitation Services, Occupational Therapy and Recreational Therapy. SWVMHI operates a psychosocial rehabilitation (PSR) treatment mall that is designed to provide didactic and experiential opportunities for consumers. Group activities are offered Monday through Friday with leisure activities scheduled during the evenings and weekends.

Staff was interviewed regarding the effectiveness of the programming and all comments were favorable. The Rehabilitation Services Department developed 3 quality indicators, which were implemented, evaluated and monitored over the past year. The indicators included monitoring staff competence to effectively lead group sessions, determining whether the quantity and quality of services provided addressed the patients' needs as prescribed on the treatment plan, and determining patients satisfaction with their level of involvement in planning for rehabilitation services.

The inspection occurred on days when there was no mall programming so groups were not observed. This break time was being used by programming staff to reevaluate the services offered, review program goals and objectives, and complete consumer satisfaction surveys in preparation for initiating the next cycle of active treatment programming.

Since the last inspection by the OIG, staff at the facility have evaluated and developed vocational training opportunities for NGRI consumers. One project involves in-house delivery for consumers who are restricted to their units. These consumers can call the Canteen and place an order for snacks or other food items that are delivered to the unit.

OIG staff did observe treatment teams. Each consumer on the unit was reviewed in considerable detail. Team members contributed information based on their areas of responsibility and in response to questions or statements from the psychiatrist. All members seemed to be knowledgeable and concerned about the consumers. Dialogue focused on the consumers' progress toward stability and discharge, medication status, and behavior. There was little discussion of longer-term goals or the consumers' goals

for themselves. Some, but not all consumers were present while their cases were being reviewed. In several of the reviews, it was noted that a representative from the CSB was present.

2. There are processes in place that support evidence-based practices.

According to the administrative and clinical staff interviewed, SWVMHI has a number of processes in place that support evidence based practices. The medical staff monitors medication adherence and effectiveness, particularly the effectiveness of PRN medications. Five of the 15 consumers interviewed reported being fully informed regarding their medications. The others reported having limited knowledge regarding the benefits of their medications but not the risks and side effects associated with its usage. Clinical staff cited cognitive-behavioral approaches as an example of evidence-based practices used by the facility.

3. The facility assures that service provision is grounded in the principles of recovery, self-determination and empowerment.

Staff stated that the facility is actively seeking to incorporate recovery principles in all aspects of each consumers treatment. One component of PSR programming is to assist the consumer with developing a recovery action plan. This plan outlines activities, contacts, skills and precautions the consumer needs to have in place in order to function within the community and to decrease the likelihood of re-hospitalization. One of the goals of the leadership team is to assure that the recovery model becomes more fully integrated in all levels of interventions within the facility. There was a noticeable contrast in the understanding of recovery principles between the clinical staff and the direct care staff interviewed. Seven of 23 direct care staff interviewed had some awareness of the recovery mode, but no one was able to recall receiving any specific training on this topic.

4. There are systems in place to measure the perceptions of consumers, families, direct care staff, clinical staff and administrative staff regarding the quality of the provision of care and services.

Administrative staff informed the team that the facility continuously seeks ways to improve communication regarding service delivery in order to enhance patient care. Satisfaction surveys are completed with consumers regarding their experiences throughout their stay. This happens both formally and informally. Contact with families occurs primarily in the context of service provision, through treatment team meetings, notifications of incidents and discharge planning. Staff is provided opportunities to express their concerns and make suggestions during morning report, unit meetings, departmental meetings and through satisfaction surveys.

Fifteen of the 21 staff interviewed indicated that the facility is receptive to their suggestions regarding the provision of services. Two staff made negative comments about the facility's openness to their suggestions.

Discharge

1. There are systems in place for effective utilization review and management.

Utilization management monitors the number of admissions, the number of discharges, and the length of stay as associated with the consumer's primary diagnosis. The UR staff work closely with the treatment teams to monitor consumers' progress and to problem-solve issues that hamper discharge. The UR Committee meets at least annually to assure that the facility is in compliance with guidelines and regulations. SWVMHI monitors the utilization of each unit.

During the OIG visit, the 16-bed Adolescent Unit had a census of only 2 consumers. One of the 2 was discharged during the inspection. The facility provided the OIG with the following utilization data regarding the adolescent unit:

Adolescent Treatment Program
Utilization Data 2004

Month 2004	Number of Admissions	Number of Discharges	Total # of Pts Served	Average Daily Census	Average Length of Stay
January	13	13	17	4.5	19.6
February	21	22	25	4.7	5.6
March	27	25	30	7.0	6.2
April	32	29	37	7.1	7.6
May	25	27	33	6.6	9.7
June	14	16	20	7.1	10.4
July	10	10	14	3.0	12.6
August	11	10	15	2.8	6.7
September	18	18	23	5.0	7.3
October	14	17	19	3.8	11.4
November	21	14	23	5.6	9.3
December	10	14	19	6.4	10.0
TOTALS	**216**	**215**	**229**	**5.3**	**9.7**

Based on data provided by the facility, the number of days the census exceeded 75% of the 16 bed capacity dropped from 7.4% in FY2003 to 0 in the first nine months of FY2005. During this same 3-year period, the number of days in which the census exceeded 50% of the16 bed capacity has dropped steadily from 24.1% in FY 2003 to 16.4% in FY 2004 to 5.1% in the first nine months of FY 2005.

Census / % Capacity	2003 / % of Days	2004 / % of Days	2005 / % of Days
0 to 4 / 25%	25 days (23.3%)	125 days (34.2%)	135 days (49.3%)
5 to 8 / 50%	192 days (52.6%)	181 days (49.6%)	125 days (45.6%)
9 to 12 / 75%	61 days (16.7%)	49 days (13.4%)	14 days (5.1%)
13 to16 / 100%	27 days (7.4%)	11 days (3%)	0 days (0%)
	365 total days	366 total days	274 total days

2. There are systems in place to assure that effective communication occurs between the consumer, facility and community liaisons regarding discharge readiness in order to assure a smooth transition of the consumer into the community and to prevent re-hospitalization.

Administrative and clinical staff revealed that discharge planning starts when the admissions coordinator reviews discharge options with the prescreener, prior to the actual admission. Initial discharge plans are to be formally developed within the first 7 days of admission when the social worker, consumer, community liaison and family members begin to actively communicate regarding discharge needs. Contact with the significant players is maintained at least weekly throughout the consumer's hospitalization and increases as discharge readiness is discussed. Social workers meet regularly with the consumer to update him/her on the discharge planning details and to elicit feedback regarding the consumer's choices and preferences.

All staff members interviewed regarding the discharge process stated that the facility has an excellent working relationship with the CSBs which enables discharge planning to be a smooth process for consumers and their families.

Environment of Care

1. The physical environment is suitable to meet the individualized residential and treatment needs of the consumers and is well maintained.

Tours were conducted in all the residential and programming units during the inspection. Overall, the facility was observed to be clean, comfortable and well maintained. Units had a bright, airy appearance. Efforts to make the setting appear more home-like were noted. This primarily involved decorations in the common areas and hallways. The bedrooms had few homelike touches.

Most of the units have the same general layout. There are conference rooms for treatment team or other staff meetings and an open nursing station which is centrally located between the wings with only a low privacy wall and no glass separating it from the

common area. As compared to the more traditional boxed-in nursing stations, this reduces isolation and distance between the nursing staff and the consumers. Frequent informal interactions between nursing staff, direct care providers and the consumers were observed. Staffing levels in the adolescent unit were unnecessarily high. There were 18 direct care and professional staff available during the day for the 2 consumers on the unit. Staff interactions were noted to be warm and caring, with consumers and staff relating to each other in an informal and friendly manner. There was a television in each of the common rooms, and a telephone for consumers' use on each unit.

The infirmary or K Unit, with a capacity of 6, had a census of 4 during the inspection. The unit was very clean, neat, and well equipped. It was well designed and nicely decorated. It had a quiet, professional feel. The unit also serves as an "outpatient" clinic for the rest of the hospital. Consumers from other units come to the medical unit for treatment of various conditions, but they continue to reside on their units. In these cases staff escort them from that unit to the infirmary. The unit also evaluates all new admissions, providing physical evaluations, including EKGs.

The three most critical capital improvement projects identified by administrative staff included:

- Replacement of 4160 electrical system
- Emergency diesel generators to service the Auditorium, Blalock, Harmon and Henderson buildings
- Roof/gutter replacement for Building 4

2. There are systems in place to assure that the environment of care is safe and that consumers are protected.

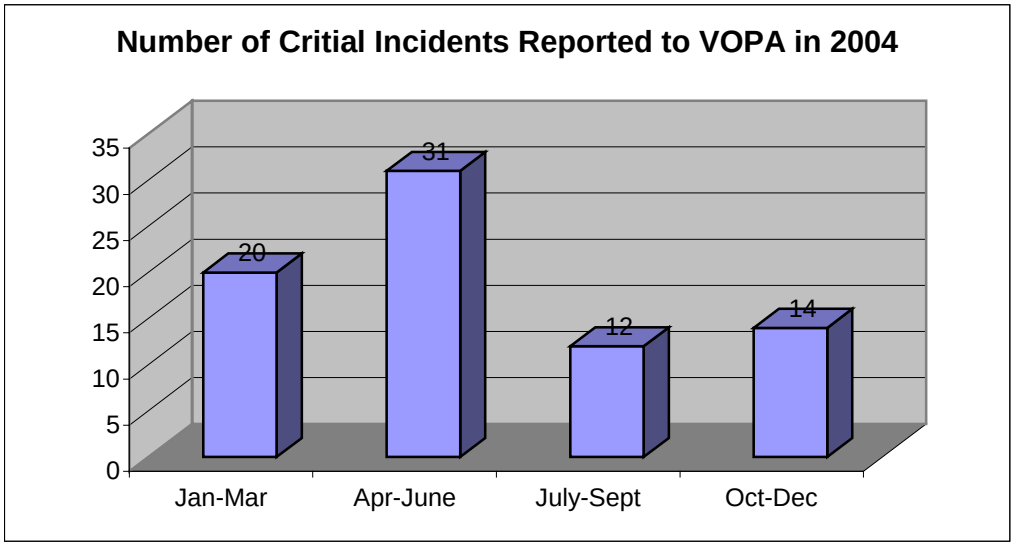
Administrative staff interviewed maintained that the safety of the consumers and staff was the foremost concern of this facility. It was reported that safety is promoted through environmental checks, on-going inspections, staff training, and the reporting systems established for identifying and monitoring serious incidents, formal/ informal complaints and allegations of abuse and neglect.

Building maintenance and safety checks are the joint responsibility of Buildings and Grounds and Campus Security. Routine rounds of the buildings are made to assure that all equipment is in good working order and potentially hazardous situations are dealt with before a problem develops. All staff is expected to report any areas that need repair or present a risk as soon as noted. Work orders are created and completed based on the levels of risk involved, with potential life, health and safety code violations attended to immediately.

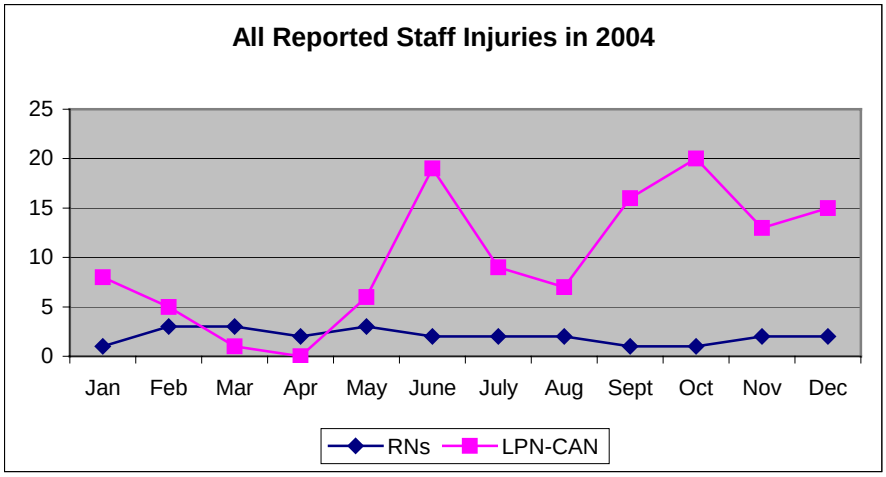
Staff are trained in key areas that have a direct impact on consumer safety, such as: fire safety procedures, managing challenging and difficult consumers, medication risks and benefits, human rights and the reporting of allegations of abuse and neglect. The facility has a risk management program that identifies, evaluates and seeks to reduce the risks associated with injuries, property loss and other areas of liability. Data is tracked for

trends regarding a number of key indicators, such as patient injuries, patient related staff injuries, allegations of abuse and neglect, formal and informal complaints, and incidents of seclusion and restraint usage.

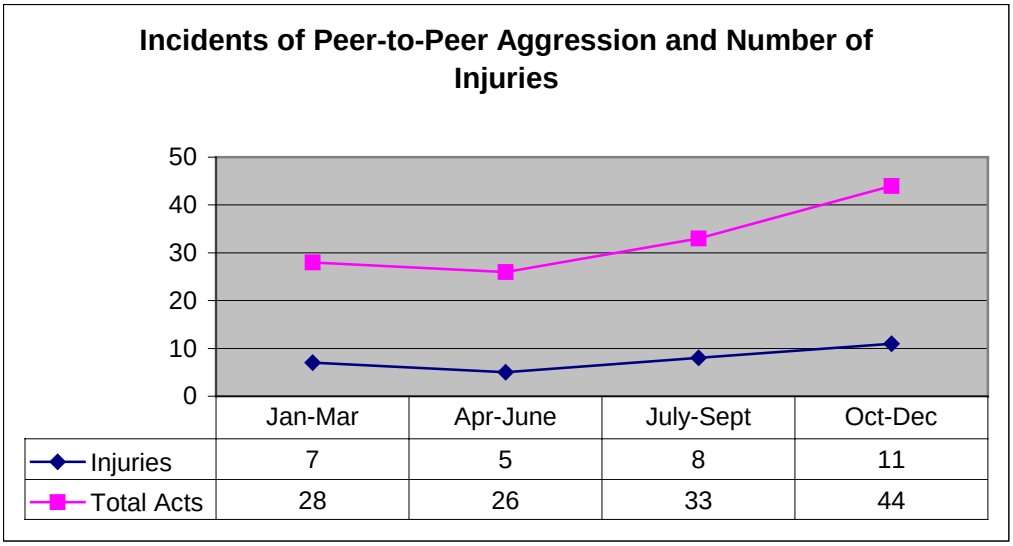
Information provided by the facility indicates that there were 77 critical incidents at the facility in 2004. The following graph shows the number of VOPA reportable incidents per quarter for 2004.



Information provided by the facility indicated that there were 195 reported staff injuries during 2004, of which 149 were patient related. The following graph shows the number of incidents of staff injuries as reported by the facility during 2004 for RNs and CNAs. Staff members having the most "hands-on" contact with the consumers sustained the highest number of injuries. The facility reported that spikes in injuries occurred because of the behavioral difficulties experienced by two consumers.



According to the data provided by the facility, there were 146 incidents of peer-to-peer aggression during 2004. Of these incidents, 20 resulted in injuries to one or both of the consumers involved. The following graph shows the total number of incidents and those resulting in injury for each quarter of CY2004.

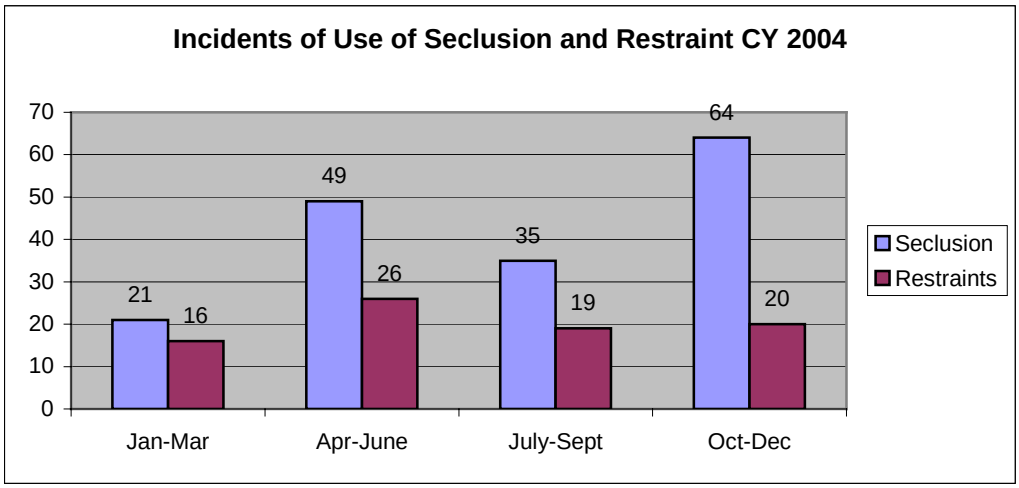


	Jan-Mar	Apr-June	July-Sept	Oct-Dec
Injuries	7	5	8	11
Total Acts	28	26	33	44

As demonstrated in the graph, interviews with nursing staff confirmed that approximately a fourth of all incidents of peer-to-peer aggression within the facility resulted in injuries to either one or both of the consumers. Staff reported that they make every effort to interrupt potentially aggressive incidents before they escalate. Each incident is reviewed in order to minimize a reoccurrence.

All staff are provided training regarding human rights and the reporting of abuse and neglect. There were 32 allegations of abuse and neglect reported in 2004, of which 7 were substantiated. Consumers and/or their LAR filed 10 formal complaints and 136 informal complaints during 2004.

The facility had 169 incidents that required the use of seclusion and 81 incidents involving mechanical restraints during 2004. Incidents per quarter for CY2004 were as follows:



Thirteen of 17 consumers reported feeling safe within the environment. Nineteen of the 23 staff members interviewed reported feeling safe within the environment. Staff did express concerns regarding a recent incident of contraband entering the facility that could have had very negative consequences. Staff on the unit where the incident occurred felt that security measures regarding contraband searches should be strengthened prior to the consumer entering the units.

Staff outlined the following as methods for keeping the units safe:

- Adequate staffing
- Good communications among staff regarding consumer care in team meetings
- Conducting risk assessments
- Ongoing observations of the consumers
- Facility inspections and drills

Quality and Accountability

1. There are systems in place to assure that the services provided from the time of admission to discharge are quality services.

SWVMHI has a quality management program. The program is intended to assure that the processes that govern quality within the setting are designed to effectively monitor, evaluate and improve patient outcomes.

Interviews revealed that the quality committee determined that the facility would focus on the following: issues identified in the strategic plan, continued development of the National Patient Safety Goals as a part of performance improvement, patient satisfaction, and high risk indicators such as falls and the use of seclusion and restraint.

Both the quality management team and risk management work cooperatively to assure that the services provided are safe and effective. The facility monitors approximately 70 quality indicators including falls, self-injurious behaviors, incidents of aggression, adverse drug reactions, deaths, medication use, staff turnover and overtime, staff and patient injuries, consumer and family complaints.

2. The facility has an accurate understanding of all of the stakeholders' perceptions regarding the services provided by the facility.

SWVMHI staff participates actively in a number of meetings in order to promote open communication with a variety of stakeholders regarding service delivery both within the facility and the region. Some of these meetings are with members of the DMHMRSAS Central Office, CSBs, and advocacy groups.

In addition, the facility conducts patient satisfaction surveys. Surveys have addressed satisfaction with food services, library services, and clinical services. Facility staff reports having strong linkages with family member groups. Communications with family members and/or LARs occur through both formal and informal mechanisms, such as during visits and through treatment team contacts.

Recommendations

The OIG has the following recommendations regarding the Southwest Virginia Mental Health Institute as a result of this inspection.

Finding #1:

The majority of staff at SWVMHI (18 of 25) were not able to describe what the facility is trying to achieve with residents. They were not clear on the mission of the facility despite the fact that the official mission statement is posted throughout the facility and is printed on the back of the employees' identification tags. A review of the current mission statement reveals that it does not clearly define the work of the facility. Only 3 of the 25 staff members interviewed were able to identify three values that have been established by the organization to guide the work of staff.

Recommendation #1:

It is recommended that SWVMHI:

- Review and revise its mission statement to describe more clearly the role of the facility and to assure consistency with the system-wide vision statement adopted recently by DMHMRSAS.
- Review and revise the organizational values/guiding principles to assure that they describe clearly how staff are to carry out their work and assure consistency with the system vision statement and revised facility mission statement.

- Take the necessary steps to assure that all staff understand the mission of the facility and that the actions of staff at all levels and the culture of the facility reflect the revised organizational values/guiding principles.

  DMHMRSAS Response: SWVMHI will organize a workgroup to review and revise the facility's Mission Statement, and the organizational values to more clearly reflect the Department's mission statement of Self-Determination, Recovery, and Empowerment. This workgroup will be composed of employees from all levels of the facility with input from the Central Office. After the revisions are completed, a training schedule for all employees will be implemented. To assure that the mission is understood at all levels it will be included in yearly training. SWVMHI will develop a mission statement and organizational values by March of 2006 and complete training by September of 2006.

Finding #2:

Utilization of the SWVMHI Child/Adolescent Unit has dropped steadily for the past several years resulting in a very low average daily census and an excessively high cost per patient day. In FY2005, this unit had an average daily census of 6. With unit capacity at 16, this resulted in average utilization of only 37.5% and cost per patient day of $1,422. The following information provides some perspective on this finding regarding the SWVMHI Child/Adolescent Unit (C/A Unit):

- The average daily census of the C/A Unit has dropped from 11 in CY00 and CY01 to 7 in CY02 and CY03 to 5 in CY04. This is a 54.5% drop in census over 4 years.
- The cost per patient day of $1,422 compared to other SWVMHI units is:
  - 180% higher than the cost of ICF ($507)
  - 158% higher than the cost of Acute Services ($551)
  - 153% higher than the cost of Extended Rehab ($578)
- The cost per patient day is 51% higher than the Commonwealth Center for Children and Adolescents ($943), the only other state mental health facility providing services to children and adolescents.
- The cost per patent day is the third highest unit cost of all 36 reporting units across the 16 DMHMRSAS operated facilities. The only per patient day costs statewide that exceed this are the Virginia Center for Behavioral Rehabilitation ($1,539) and the SWVMHI Med/Surg Unit ($1,483). It is noteworthy that this SWVMHI Med/Surg Unit cost of $1,483 is the highest of the 5 Med/Surg Units in the state facility system and is 25% higher than the second highest Med/Surg Unit (Central Virginia Training Center at $1,187).

Recommendation #2:

It is recommended that DMHMRSAS and SWVMHI conduct a study with the involvement of a broad range of stakeholders to:

- Determine the level of need for publicly operated inpatient services to seriously emotionally disturbed children and adolescents in the southwest region who cannot be served in less restrictive settings.
- To develop a plan to meet this need in the most appropriate and cost effective manner.
- Determine what portion of the resources currently deployed to the SWVMHI C/A Unit can be more effectively utilized to address the needs of seriously emotionally disturbed children and adolescents with the goal of providing services closer to home in less restrictive and less costly settings.

> *DMHMRSAS Response: DMHMRSAS appreciates the OIG undertaking an assessment of Adolescent Service needs at SWVMHI as well as the Commonwealth Center for Children and Adolescents (CCCA) at an earlier date. The recommendations concerning the Adolescent Unit at SWVMHI and the CCCA facility will be reviewed and assessed by an internal workgroup with the Assistant Commissioner for Community Services, the Assistant Commissioner of Facility Management, representatives from the Office of Child and Family Services and the Office of Facility Quality Improvement as well as representatives of SWVMH and CCCA. The review will take into consideration variables such as: utilization, cost-effectiveness, and resource allocation. After initial review which should be concluded by April of 2006 Department representatives will convene a meeting with the OIG to determine next steps with a broader stakeholder involvement.*